MARYLAND STATE LOAN REPAYMENT PROGRAM (SLRP)
PART I- Candidate Information
APPLICATION TIMELINE: SRPING (MARCH 1 TO APRIL 15); FALL (SEPTEMBER 1 TO OCTOBER 15

Section A: Candidate Information

1. Last Name: _____ First Name: MI:
2. Social Security Number: _____
3. Date of Birth: _____
4. Previous name under which records may have been kept: _____
5. Permanent Mailing Address: _____
   City: _____ State: __ Zip: _____
6. Home Phone: _____ Work Phone: _____ Cell Phone: _____
7. E-mail address: _____
8. Current place of employment: _____
   Address/City/State/Zip: _____
   MD County: _____ Salary: _____
9. Are you a citizen of the United States or a U.S. National? ☐ Yes ☐ No If no, explain: _____
10. Gender: ☐ Female ☐ Male
11. Are you Hispanic or Latino**APPLICATION TIMELINE:**
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: ☐ Yes ☐ No

12. Race(s): Check all that apply
    ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
    ☐ Hawaiian/Other Pacific Islander ☐ White/Caucasian
13. Have you ever been convicted of a felony?
    ☐ Yes ☐ No If YES, explain: _____
14. Have you ever been disciplined, suspended or dismissed by administrative, military, or other authorities?
    ☐ Yes ☐ No If YES, explain:_____
15. Have you ever breached an obligation for service to a federal, state, or local governmental entity (even if the obligation was ultimately paid in full)?
    ☐ Yes ☐ No If YES, explain: _____
16. Have you ever breached a service obligation, even if the obligation was ultimately fulfilled?
    ☐ Yes ☐ No If YES, explain: _____
17. Do you have a judgment lien against your property for a debt to the United States?
    ☐ Yes ☐ No If YES, explain: _____
18. Have you ever been excluded, debarred, suspended, or disqualified by a Federal agency?
    ☐ Yes ☐ No If YES, explain: _____
19. Do you have any unserved obligation(s) for service to a federal, state, local government, or other entity, with the exception of the U.S. Department of Health and Human Services' Primary Care Loans, Exceptional Financial Need Scholarships, and Financial Assistance for Disadvantaged Health Professions Students?

☐ Yes ☐ No If YES, explain: _____

20. Do you have an existing service obligation or a future service obligation with any other loan repayment program?
☐ Yes ☐ No If YES, explain: _____

21. Are you now in default on any eligible higher education loan?
☐ Yes ☐ No If YES, explain: _____

22. Have you ever had any debts written off as uncollectible?
☐ Yes ☐ No If YES, explain: _____

23. Have you ever had any service or payment obligation waived?
☐ Yes ☐ No If YES, explain: _____

24. Have you ever violated court-ordered child support or been delinquent in child support payments?
☐ Yes ☐ No If YES, explain: _____

25. How many hours per week do you plan to work at this site during your 2-year commitment? _____

Section B: Medical School Information

Name of Medical School: _____

Address: _____

City: _____ State: __ Zip Code: _____

Date of Graduation: _____ Degree Earned: _____

Awards/Fellowships/Certificates Earned: _____

Section C: Medical Residency Information

1. Name of Institution/Agency: _____
2. Address: _____
3. City: _____ State: __ Zip Code: _____
4. Specialty: _____
5. Subspecialty: _____
6. Date Residency Began: _____ Date of Residency Completion: _____
7. Awards/Fellowships: _____
8. Have you completed a community-based rotation in medical school or residency? ☐ Yes ☐ No
   If yes, please describe: _____

SECTION D: MEDICAL LICENSING INFORMATION

☐ I have a Maryland Medical License

License Number: _____

Date of Renewal/Expiration:_____

☐ I do not have a Maryland Medical License

State(s) of current unrestricted licensure: _____

Pending/temporary licensure in Maryland: _____

Has your medical license ever been revoked or suspended? ☐ Yes ☐ No

Reason for revocation or suspension of license: _____

SECTION E: EDUCATIONAL ASSISTANCE HISTORY

1. Are you **CURRENTLY** serving an obligation(s) to any other agency for loan repayment or scholarships?

   ☐ Yes ☐ No If YES, please describe: _____

2. Have you **EVER** breached any service obligation(s), contract(s), etc.? ☐ **Yes** ☐ **No**

   If YES, please explain: _____

3. Have you **EVER** defaulted on an educational loan? ☐ **Yes** ☐ **No**

   If YES, please explain: _____

4. Are you **CURRENTLY** in default on an educational loan? ☐ **Yes** ☐ **No**

   If YES, please explain: _____

5. **Have you applied for any other loan assistance repayment programs?** ☐ **Yes** ☐ **No**

   If YES, please name the program(s) and describe the service(s) agreement: _____

(YOU MAY ONLY ACCEPT ONE LOAN REPAYMENT AWARD.
YOU MUST CONTACT CHRISTINA SHAKLEE IF YOU DECIDE TO ACCEPT AN AWARD WITH ANOTHER PROGRAM AND WISH TO WITHDRAW YOUR APPLICATION FOR THIS MARYLAND SLRP PROGRAM.)

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Section F: Lender Information

- COMPLETE ONE SECTION FOR EACH LENDER AND EACH ACCOUNT NUMBER.
- IF YOU HAVE MORE THAN ONE LOAN WITH A PARTICULAR LENDER, PLEASE COMPLETE ONE SECTION FOR EACH LOAN ACCOUNT NUMBER.
- PLEASE TOTAL THE AMOUNT OF LOANS AND RECORD A COMBINED FIGURE AT THE BOTTOM OF THE PAGE.

Lender: ______

Account number: ______

Month/Year loan goes/went into repayment: ______

Current Outstanding Balance: ______ Monthly due date:______ Monthly payment: ______

Has this loan been consolidated? ☐ Yes ☐ No If YES, please list the prior lenders: ______

Lender: ______

Account number: ______

Month/Year loan goes/went into repayment: ______

Current Outstanding Balance: ______ Monthly due date: ______ Monthly payment: ______

Has this loan been consolidated? ☐ Yes ☐ No If YES, please list the prior lenders: ______

Lender: ______

Account number: ______

Month/Year loan goes/went into repayment: ______

Current Outstanding Balance: ______ Monthly due date: ______ Monthly payment: ______

Has this loan been consolidated? ☐ Yes ☐ No If YES, please list the prior lenders: ______

Lender: ______

Account number: ______

Month/Year loan goes/went into repayment: ______

Current Outstanding Balance: ______ Monthly due date: ______ Monthly payment: ______

Has this loan been consolidated? ☐ Yes ☐ No If YES, please list the prior lenders: ______

TOTAL LOAN AMOUNT: _____

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SECTION G: PRACTICE SITE INFORMATION

Practice Name: _____

Address: _____

City: _____ State: __ Zip Code: _____

County: _____ DIRECT Office Telephone: _____

Urban ☐ Rural ☐

Is this a: ☐ Group Private Practice ☐ Individual (solo) Private Practice

☐ Federally Qualified Health Center (FQHC) ☐ Public Health Clinic

☐ Hospital ☐ Other (please indicate) _____

NOTE: Only public or nonprofit (501-C-3) practices/clinics are eligible to be Practice Sites for participation in the SLRP Program.

Is the owner(s)/employer(s) willing to support you in this endeavor? Yes ☐ No ☐

If YES, please have the owner(s)/employer(s) complete and return the Practice Site Confirmation page (PART II)
http://fha.dhmh.maryland.gov/ohpp/SitePages/pco-larpforms.aspx

Is this a new practice site for you? ☐ Yes ☐ No

If not:

How long have you been working at this practice site? _____

How many hours a week are you working at this practice site? _____

Have you spent more than 7 weeks (35 days) away from the practice site for holidays, vacations, continuing professional education, illness, or any other reason during this period of employment?

☐ Yes ☐ No If **YES**, please explain: _____

Section H: Personal Statement

(THESE TOPICS ARE SCORED AND MUST BE ADDRESSED TO BE CONSIDERED FOR THE SLRP)

Briefly answer:

1. Can you demonstrate your commitment to work in an underserved area? _____

2. What is your intention to stay in an underserved area? _____

3. How long are you willing to practice in an underserved area (HPSA-Health Professional Shortage Area)?

☐ **2 years** ☐ **3 years** ☐ **4 years** ☐ **>4 years**

Section I: References

Please list the name, job title, and e-mail address of 3 professional references

	Name	Job Title	E-MAIL Address
1.			
2.			
3.			

Section J: Certification

You may send the application by e-mail and fax the signed Section J: Certification/signature page to fax number 410-333-7501, or you may send the printed signed application by mail (see Page 2, above)

All the information on this application is true to the best of my knowledge.
By signing this certification form you are allowing your employer and your affiliated lender(s) to disclose the requested information in Parts II, III, and IV of this application to the Maryland Department of Health and Mental Hygiene and the Maryland Higher Education Commission on your behalf.

IF ASKED by the SLRP or the Maryland Higher Education Commission, I will provide proof of the information I have given on this application.

_____ _____

Candidate's Signature Date

(Please fax signature page to fax number 410-333-7501 or mail with application)